Witness Name: John Nelhams
Statement No: WITN0680001
Exhibits: Nil
Dated: 17 September 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JOHN NELHAMS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 04 March 2020.

I, John Nelhams, will say as follows: -

Section 1: Professional History

1. My name is John Nelhams. My date of birth is GRO-C 1969 and my address is GRO-C Lincolnshire, GRO-C

2. I am a credit manager for a finance company based in London. I have worked at this company for 10 years, though I have been off sick for the last 18 months or so.

3. I have previously worked for a number of international financial companies in finance positions and in intellectual property law involving trademarks.

4. From mid-July 1985 to the end of September 1985 I was a stock controller at the North London Blood Transfusion Service, based at Edgware General Hospital on Deansbrook Road, London.

5. I have never been a member of any committees or groups relevant to the Inquiry's Terms of Reference.

6. I have not provided any evidence or been involved in any other inquiries, investigations, criminal or civil litigation that may be relevant to the Inquiry's Terms of Reference.

Section 2: North London Blood Transfusion Service

7. In July 1985 I left school after my O-levels and decided to begin working instead of completing my A-levels. This was in the middle of a deep recession and I had friends at university who were struggling to find work. My sister was a blood donor attendant nurse at the North London Blood Transfusion Service at the time. Through this connection I was able to get a temporary position as a stock controller with the Blood Transfusion Service.

8. I started working at the centre attached to Edgware General Hospital, which was near to where I lived at the time. I was not given any formal training. The job involved the organisation and preparation of blood pursuant to orders made by various hospitals and clinics across Greater London and Hertfordshire.

9. Blood was collected by a large lorry that was converted into a mobile clinic. It would visit different sites all over the region, with a team comprised of a doctor and 4 or 5 donor attendant nurses, one of whom my sister. They would take blood from donors and the nurses would monitor the donors as blood was taken. This would then be returned to the on-site laboratories where it would be checked to ensure it was sealed. The blood was then labelled according to the blood group.

10. The collected blood was then taken into a large walk-in fridge, approximately 30 feet by 40 feet. On one side was a wall of wire racking, and on the other side was a conveyer belt of plastic rollers. It was connected to the laboratory with a big wire caged door to enter. The lab assistants would come through with a tray of blood or plasma and put it on the rollers to be sent down onto the racks in the fridge.

11. I would take a daily stock check of the blood fridge. The blood was packed in date order, with a date code printed on the pack. We packed the blood on the basis of 'oldest out first' with the oldest packs at the back of the shelves. Fresh whole blood was stored in pint packs, which was a large polythene pack, upon which was a large printed letter that specified what blood group and rhesus factor the blood belonged to.

12. My role was to organise the preparation of a box of blood as requested from a hospital or clinic. The admin ladies would take calls from the hospitals saying what blood was needed. The calls would come in at any time throughout the day, though most hospitals would place regular orders as to what they required. They were able to plan how much blood they would need for the number of operations to be performed that day, or for whatever other reason. On occasions an emergency would arise, for example a car accident or something similar, and a courier was sent to collect the packs.

13. I would receive a hand-written note from the admin ladies that listed the blood required by the relevant hospital. I went into the fridge in an orange parker, which was provided for warmth. I put the blood packs in the box based on the order. I then took this to the workstation outside, where there was a rudimentary computer with a barcode scanner. We were only provided with thick warm gloves, oven style, when we were in the freezer or using dry ice. Gloves were not provided for safety reasons.

14. I used the scanner to record the barcode of the blood packs, and typed the order into the computer. It then printed out a slip to go in the box for delivery. I then stuck the hand-written note on the top of the box. The courier would then come in, state what hospital he had come from, and then take the box away to be delivered.

15. I recall vividly the differences in appearance between concentrated red blood cells, that were much thinner in density, and packs of plasma. Plasma appeared as a cloudy dark yellow colour that would come in polythene packs to be stored in the fridge or glass bottles to be stored in the freezer. This would sometimes come in peculiar card boxes, and this was also frozen.

16. We did not receive many requests for factor products. Most of our orders were for whole blood products. I do however recall the factor products came in small glass bottles, about 2 to 3 inches tall and holding approximately 100ml of what looked like water. The bottles were labelled Factor VII, Factor VIII etc. These were stored on a separate rack on their own.

17. In one corner of the big fridge was a stack of boxes with 'biohazard' tape drawn around it. This stack was comprised of between 10 and 15 boxes, about 2 to 3 feet high. When I first started the job, my manager, who I believe was called Alan Flood, very clearly told me to stay away from the 'infected factor VIII'. He told me not to go

anywhere near the boxes, and he said that it all 'had to go back', though he did not say where to. He said they were contaminated with AIDS.

18. I noticed that some of the vials were missing from the boxes. About one third of the boxes, amounting to around 3 or 4 vials, were missing from those that were visible. The boxes themselves were covered in dust. During my time working at the service, I never had any reason to go near the infected batches and I was told never to dispense them. I was only told that if one of the bottles broke, I should stay well away not touch it and call somebody immediately.

19. The infected bottles of factor products remained in the corner of the fridge for my entire time working at the North London Blood Transfusion Service. I never saw them being dispensed, and I did not see them leave the corner of the fridge. I suspect that they didn't know what to do with it, and they just stood there collecting dust. I have no idea where it would be sent to be destroyed.

20. Plasma products would come in from the laboratories in glass bottles similar to sterilised milk bottles. If the laboratory had put these in the freezer, they could explode very easily. I had the job of cleaning the plasma out when it exploded. On occasions I did not wear any gloves because it was easier to collect the spillages. There was no other protective equipment. I used a scraper like I was cleaning a car windscreen. The plasma resembled butterscotch and was extremely sticky. For all I know it could have been infected. I simply put all the collected waste into a bin liner, which was then placed in the waste bin.

21. On occasions we were unable to meet the demand for blood and blood products. We used a log sheet and a large graph on the wall of the office. We used a ruler and a pen to show much blood had been used and dispatched. This helped to identify a trend for the demand across different hospitals and clinics.

22. Our supplies would sometimes become stretched. Although we were in contact with other blood banks across London, including BPL at Elstree, we could not always gather the supplies to meet the demands for blood. As a result, we would contact the Army blood bank in Tooting.

23. The army would then send in supplies from their blood bank to meet our demands. The blood was packed in exactly the same way as our products. This would happen

quite frequently, maybe once or twice a month, with the army themselves delivering the blood to us at Edgware General Hospital.

24. On occasion we would require a specific and rare blood group. If this was required for a serious accident, the patient could need up to 15 pints of blood. We would only ever have up to 5 pints of AB-, for example, which makes up less than 1% of the population. In these circumstances, blood banks were called from all over London to meet the emergency demand for a rare blood group. At the time, there was less diversity in the population. If there was insufficient supply of a particular blood group then O- would be administered, though this is not ideal for the patient and can cause some health problems for the recipient further down the line.

25. I remember that we received requests from Schrodells laboratory, which I believe was based in Hertfordshire. Schrodells laboratory would purchase expired blood from our blood bank. Whole blood had a shelf-life of 6 weeks. If this blood then expired, Schrodells laboratory would buy it off us for the purposes of research. This happened maybe once or twice a month.

26. All the blood that was collected by the North London Blood Transfusion Service was tested. I do not recall all the diseases that it was tested for, but I remember a donor questionnaire being filled in. If a donor was a high-risk category, such as homosexuals at the time, they would put a label on the pack flagging this.

27. We were certainly aware of issues and the risks associated with infected blood at that time. By 1985 we were acutely aware of AIDS, as it was perceived to be prevalent among the homosexual community. As I said earlier, when I first started, the infected factor products in the corner were simply described to me as 'having AIDS'.

28. The only knowledge I had about the risks associated with blood was what I knew from school. I was not given any form of risk assessments or documents to sign. I was not given any instructions or information about hepatitis, whether if hepatitis B or non-A non-B hepatitis. The only precautions were to wipe up a cut straight away and report it if I broke a bottle or spilt a pack of blood. If I ever cut myself I just wiped it down and carried on.

29. I remember that we stored our sandwiches and chocolate bars in the walk-in fridge on a free shelf next to the packs of blood, at the time this was accepted practice and we thought nothing of it.

30. We were not given masks, gloves or protective suits, and I only ever wore gloves to keep my hands warm in the big fridge.

31. I finished working at the North London Blood Transfusion Service in September 1985, when I went to work for a Jewish charity in Golders Green as a trainee accounts clerk. I never returned to work with blood or within the blood industry. My sister remained there for a further 2 years, and worked there for 4 to 5 years in total.

Section 3: Other Issues

32. I have no other information that may be considered relevant to the Inquiry's Terms of Reference.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 17th September 2020